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The Decision to Die: An Investigation into Assisted Suicide

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THE DECISION TO DIE: AN INVESTIGATION INTO ASSISTED SUICIDE

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Abstract

As health care technology develops so must society's ethics concerning human life. Assisted suicide, or the act of providing a terminally ill patient with the means to end his or her life, is a highly controversial topic. Until the debate over whether there is a right to die is settled, patients can still protect their right to control their own medical treatment by producing an Advanced Directive, or document intended to inform others of a patient's end-of-life wishes.

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1 Background

Around 460 B.C. a man whose name has endured for over 2,000 years was introduced to the world (Hutchins, 1952). Before his death around 360 B.C., Hippocrates (Figure 1) wrote a document that has remained *the* controversial oath for human medicine. It is not an unreasonable assumption that most patients upon hearing their physician recite the beginning of the Hippocratic Oath: "…swear[ing] by Apollo the physician and AEsculapius, and Health, and All-heal, and all the gods and goddesses…"; would promptly change doctors. In 1995 the Hippocratic Oath was revised from the above mentioned "gods and goddesses" to "the Almighty" along with other modifications that recognized the changing times (Keränen, 2001). But with the debate over assisted suicide still in its infancy, there was one important idea in the Hippocratic Oath the revisers neglected to address:

I will neither prescribe nor administer a lethal dose of medicine to any patient even if asked nor counsel any such thing nor perform act or omission with direct intent deliberately to end a human life.

– Hippocratic Oath, translated by Adams, F. in 1886.

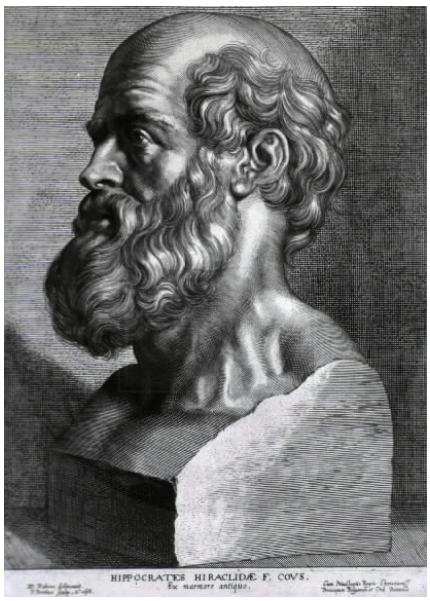

Figure 1: Engraving of the Father of Medicine, Hippocrates, created by artist Peter Paul Rubens in 1638.[1]

In 1990, concern rose in the United States over a doctor who was assisting in the death of ill patients. A trial ensued, finding Dr. Jack Kevorkian guilty of second degree murder for which he was sentenced to 10-25 years in prison. In 2004, Dr. Kevorkian was denied a request for parole (CourtTV, 2001). Even incarcerated, Dr. Kevorkian remains a proponent of assisted suicide, displaying his distaste for medical ethics in his book description of the above-mentioned document as "the Hippocratic Oaf" (Kevorkian, 1991).

Doctors graduating from medical school swear by the Hippocratic Oath; vowing to save and not to "deliberately end a human life". Some question the integrity of doctor training, believing doctors are being brainwashed that not matter what the circumstances, they must keep patients alive as long as possible. Death emerges as a contradictory option for a facility centered on preserving life. Basson (1981) elaborates, finding it "ironic that the same medical technology that permits these doctors to dedicate themselves to prolonging life has created a new class of patients: diagnosed, perhaps palliated, but uncured and alive, who might seek death." This places today's physicians in an awkward position of authority in deciding who should live, and who should die. It is unfair to expect any person, doctors included, to take responsibility for another's death. Legally, most of the United State is currently in favor of doctors who would wish to avoid this topic, although according to Meier *et al.* (1998), the majority of public support legalization. Oregon is currently the only state where assisted suicide is legal, along with a handful of countries, including the Netherlands (Groenewoud *et al.*, 2000). The United State's Supreme Court (USSC) ruled that patients have a constitutional right to deny any form of treatment they wish; but not the constitutional right to die a comfortable, controlled death through assisted suicide (Miller *et al.*, 2002).

Palliative care is that which is no longer centered around treatment but rather comfort and management of symptoms while the patient waits to die. At extreme stages of palliative care, it is

unlikely patients would have neither the ability nor opportunity to take their own lives, therefore making a voluntary death possible only with the assistance of another (Anderson, 2007; Frontline, 1994; Council of Palliative Care Australia, 2006). Assisted suicide is when another assists in the death of a terminally ill patient by providing that patient with the means to take his/her own life, such as a doctor giving a patient a lethal dose of drugs to take on his/her own (Humphry, D. 2002). Euthanasia, on the other hand, is when assistant of the patient is actively involved in the death, such as a doctor injecting a lethal dose of drugs (Compassion and Choices, 2005). There have been documented accounts in the Netherlands of involuntary euthanasia, when a doctor terminates a patient's life without his/her being forewarned (Cohen-Almagor, 2003). Opponents of assisted suicide fear the moral implications and wrongful deaths that could occur as a consequence of legalization such as the opportunity of life ending frauds to derive a potential scapegoat for the actions that occurred. It provides the opportunity for others to coerce a patient into an early death, based on personal prejudice.

Suppose that a terminally ill patient requested a lethal dose of drugs from his/her doctor. The patient was informed of his/her imminent death, and of the different medical treatments available to control symptoms. This patient though, desires a controlled and peaceful crossing, rather than waiting in distress for its arrival. This theoretical example is intended to demonstrate what proponents of assisted suicide might consider a "rational suicide". Basson (1981) disputes the expression "rational suicide", saying that no such thing is possible. As explained by Hauerwas (1981) there lies an uncertainty concerning a person's right to autonomy; which would imply that suicide is not only a right, but also justified. At the same time though, most people have the belief that if a person wants to commit suicide it is because they are unwell. And according to our society, people who are unwell need to be helped, not killed. There have been a handful of doctors, though, who have admitted to the later, and without notifying the patient. Although some might define this as murder, it is also known as "involuntary euthanasia" (Groenewoud, 2002). Many severe palliative care patients, lose the capacity to make and/or communicate their desires, especially in the last days to weeks of life. When doctor sees death as the only relief available for a patient; he may see death as a way to give the patient the dignity of peaceful end to an unbearable life, without upsetting the patient with the politics of the matter. It would be very easy for a doctor to end a patient's life without the patient ever knowing it was a murder in the name of mercy; an early end to the last few days of suffering.

End-of-life care is a major concern in the debate of assisted suicide. The argument continues that end-of-life care first needs to be improved which could result in a decreased number of requested assistance with suicide. It is hard to say that palliative care is living up to standards when (Appendix I), terminal restlessness – described as an agitated delirium – is said to be normal and progressive for long-term patients (Anderson, 2007). Improvements in the education and practice of end-of-life care have recently been noted, but the fact remains that terminal restlessness is prevalent (Bachman, 1996). Merging the definitions of 'terminal' and 'restlessness' together from *The Merriam-Webster Dictionary* would read as: extreme or "hopelessly severe" discontent. Terminal restlessness is said to be a result of the build up of toxins in a patient's body. The toxins are the result of decreased in organ function exhibited in a dying patient. Drug treatments are available to control the muscle contractions, only one of the symptoms of terminal restlessness. For severely restless patients, sedation is implemented (*Confusion and Terminal Restlessness*, 2002).

Oregon – the only state in the United States to legalize assisted suicide – prohibits the act for mentally unstable patients (*The Oregon Death with Dignity Act*, 1994). In other words, a patient who is deemed depressed, would not qualify for assisted suicide. This is implemented as preventive act because depression is a treatable condition and once treated, there is the possibility

that assisted suicide will no longer be desired. Patients who are aware that their death is near, often exhibit the same stages of grief as if they were to have someone close to them die: acceptance, depression, bargaining, anger and denial (Kubler-Ross, 1969). A patient may bounce from one stage to another and back again, or may never encounter a specific stage at all. This would imply that any terminally ill patient, according to Oregon law, must reach the stage of acceptance before being considered for assisted suicide. An elderly woman who had reached this stage is described in the following excerpt from the book*, Caring for Older Adults Holistically* (Anderson, 2007):

> *This woman has accepted that she is going to die. As is common with so many people, she does not want to interact with the world anymore. She is done; she has accepted the fact that she is close to death. Notice that she has her call light in hand "just in case". She also must have slowing circulation as indicated by the afghan, blanket and oxygen."*

Keeping this excerpt in mind, the following is a list of symptoms for depression at www.depression.com:

1. *Constant feelings of sadness, irritability, or tension*
2. *Decreased interest or pleasure in usual activities or hobbies*
3. *Loss of energy, feeling tired despite lack of activity*
4. *A change in appetite, with significant weight loss or weight gain*
5. *A change in sleeping patterns, such as difficulty sleeping, early morning awakening, or sleeping too much*
6. *Restlessness or feeling slowed down*
7. *Decreased ability to make decisions or concentrate*
8. *Feelings of worthlessness, hopelessness, or guilt*
9. *Thoughts of suicide or death*

How many patients facing death, do you suppose would experience these same symptoms? Acceptance is apparently different in a dying individual than in one without a death sentence. In the above description of the woman who had accepted her death, she is described as "not want[ing] to act with the world anymore", and as being "done". She is also described as "hold[ing] the call light in her hand 'just in case'", suggesting a certain fear associated with her pending death. If any healthy individual were to step into a doctor's office and describe these symptoms, they would most likely find themselves diagnosed as depressed and prescribed a regimen of therapy and anti-depressants. On the other hand, if a dying patient describes these symptoms, it is acceptance.

> *It is important to recognize that mental health problems and illnesses may be present across all identified patient populations and in this way people with a mental health problem or illness do not represent a distinct and separate group in the community.*
>
> – Council of Palliative Care Australia, 2006.

Suicide, once deemed illegal in the United States, is viewed differently throughout the world. It is not uncommon for suicide now to be viewed as a copout for individuals too weak to deal with the everyday struggles of life. Those who propose the legalization of assisted suicide find a distinction between suicide and assisted suicide; one – suicide – committed for reasons of

revenge, altruism, or anomie (Durkheim, 1951) and the other that follows an extensive illness where one cannot bear the suffering any longer – assisted suicide. As given by one a well known pro-assisted suicide organizations, *End of Life Choices,* assisted suicide is: "Providing the means (drugs or other agents) by which a terminally ill, mentally competent person can take his or her own life under carefully controlled conditions." One can see that this definition leaves plenty of room for interpretation. Saying "drugs or other agents" is extremely vague. There are a variety of ways that a doctor could assist a patient in death; for example, Doctor Jack Kevorkian used a suicide machine he had built to assist in the suicide of patients. Recently, *End of Life Choices,* combined with another pro-assisted suicide group to form: *Compassion and Choices.* They have since, revised their definition of assisted suicide, saying that a better expression would be "aid in dying"; defined as: "the process that allows mentally competent, terminally ill adults to request a prescription for life-ending medication from their physician. The medication must be self-administered."

Final Exit: The Practicalities of Self Deliverance and Assisted Suicide (1991), by author Derek Humphry – founder of the Hemlock Society – is a controversial hand guide of suicide methods intended for those suffering from a terminal illness. Humphry's fight to defend an individual's right to control his or her own death was prompted by the death of his wife, Jean. With help from her husband, in 1975, Jean ended her life by drinking tea spiked with lethal dose of drugs. In Humphry's *Final Exit* (1991), he recommends the use of a plastic bag as a safety precaution for anyone who is committing suicide. It seems a bit unusual that somebody who is going to voluntarily kill him or herself would need to set up a safety net. Although for an already suffering patient, a failed suicide attempt could result in further complications and could severely impact the emotional state of the patient.

2 Dr. Jack Kevorkian and the Suicide Machine

2.1 "Dr. Death"

The name "Dr. Death" was given to Jack Kevorkian (Figure 2) by colleges as a pathology resident in Michigan during the 1950s. During his residency at Detroit Receiving Hospital, Kevorkian began to develop his interest in death, and his hunt to find treasure in somebody else's garbage. A greater number of patients die at night, which is primarily the reason why Jack Kevorkian requested the night shifts. He spent those nights conducting, as he called them, "Death Rounds"; studying the dying patients' eyes; taking a picture of the eye at the exact moment of death. His goal was to learn how to read the eyes of a dying patient in order to estimate how many minutes were left for resuscitation, and also to determine the blood flow to the brain, in order to predict whether the patient was brain dead or not. A common factor throughout Kevorkian's research was his interest in making use out of the dead, exemplified by ideas that Kevorkian had attempted to research. One of the studies he had proposed was to travel to the battlefields of Vietnam in order to experiment with the procedure of directly transfusing the blood from a dead soldier into a wounded soldier. Another one of Kevorkian's ideas was that prisoners to be executed should be allowed to supply

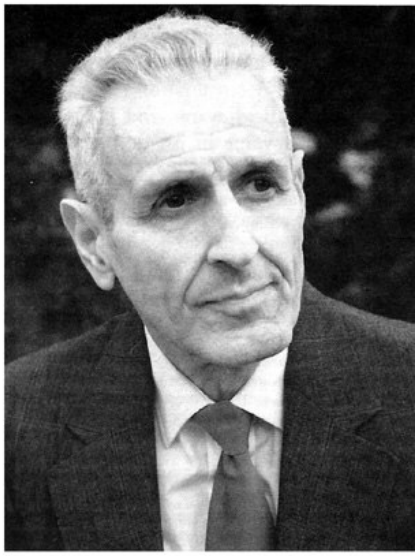

Figure 2: Dr. Jack Kevorkian*

their bodies for research. He believed that with the prisoner's consent, he/she could be put to sleep before execution and the organs donated to save lives, or that experiments could be preformed on the prisoner's body (Frontline, 1994; Betzold, 1993).

His apparent obsession with the dead, along with his eccentric style of art (Figure 3) led Dr. Jack Kevorkian to develop a less than popular reputation in the medical community, admitting in later years that he was "the laughingstock of the hospital" (Betzold, 1993). His reputation was tested even further when he began assisting patients with their own suicides. Interesting to note, that years earlier, and without Kevorkian's knowledge, his two sisters had requested help from their mother's physician to end her painful suffering from cancer. Jack was only informed in later years of his sisters' failed attempts in ending their mother's pain.

Figure 3: One of Dr. Jack Kevorkian's paintings, *My God to Thee.*

Preoccupation with death came easily to the Kevorkian family, having emigrated from Armenia to avoid the slaughter of millions conducted by the Turks:

> *I wish my forefathers went through what the Jews did. The Jews were gassed. Armenians were killed in every conceivable way. Pregnant women were split open with bayonets and babies taken out. They were drowned, burned, heads were smashed in vices. They were chopped in half.*
>
> – Jack Kevorkian, from (Betzold, 1993).

Although Kevorkian was affected by the stories of the torture his family had escaped, and by the loss of his parents (his father's death resulting from a heart attack (Betzold, 1993)) he admits in his book *Prescription: Medicine* (1991):

> *Euthanasia wasn't of much interest to me until my internship year, when I saw first-hand how cancer can ravage the human body. The patient was a helplessly immobile woman of middle age, her entire body jaundiced to an intense yellow-brown, skin stretched paper-thin over a fluid-filled abdomen swollen to four or five times normal size. The rest of her was an emaciated skeleton: sagging, discolored skin covered her bones like a cheap, wrinkled frock.*
>
> *The poor wretch stared up at me with yellow eyeballs sunken in their atrophic sockets. Her yellow teeth were ringed by chapping and parched lips to form an involuntary, almost sardonic "smile" of death. It seemed as though she was pleading for help and death at the same time. Out of sheer empathy alone I could have helped her die with satisfaction. From that moment on, I was sure that doctor-assisted euthanasia and suicide are and always were ethical, no matter what anyone says or thinks.*

He had admitted to helping over 130 people commit suicide (CourtTV, 2001), only 93 of which were documented in newsprint (Appendix III; ERGO, 1994). Kevorkian was clearly stated his opinion concerning the issue; "I call it a medical service. Youk [a patient] came to me and said, 'Please help me'. The aim was a final solution to incurable agony" (CNN, 1999). Despite his words, many skeptics of Kevorkian believed his motives for assisting in the deaths were egoistic

(*Dickey, N., M.D. from the AMA:* Frontline, 1994). A video interview of two women who he helped commit a double suicide shows Kevorkian questioning the women about donating their organs after they pass. His inquiry was left behind when a cuckoo clock disturbed the interview and distracted the two ladies (Frontline, 1994). Although Dr. Kevorkian may have been right to try to make something useful out of something dead, he was only adding fuel to the fire set by his opposition. The distaste for Dr. Kevorkian's work in the medical community was displayed openly. Not only did the Michigan State Board of Medicine revoke his medical license but the American Medical Association (AMA) – opponents of assisted suicide – also condemned him. By the late 1980's it has been said that no hospital would have hired him (Frontline, 1994).

2.2 The Thanatron

Before 1994, when it was ruled by the Michigan Supreme Court in *People v. Kevorkian* that there is no federal constitutional right to assisted suicide (Nightingale Alliance), there was nothing that prosecutors of Dr. Kevorkian could actually charge him with. By definition, a suicide – not a murder – had taken place. Not Kevorkian's, but the patients own actions directly preceded their death. Many of the patients Dr. Kevorkian assisted, would not have been able to successfully commit suicide on their own, therefore a Kevorkian designed a device that the patient could use to aid them in this act (Figure 4). By the late 1980's, the infamous "death machine" – directly translated from the Greek word 'thanatron' – was ready for use (Frontline, 1994).

Homemade, the Thanatron was built out of random tools, and even included toy parts. The idea behind the machine was for the patients to be able to inject themselves with a fatal combination of drugs by simple pressing a button. The procedure began with the patient being given an intravenous saline drip. Once the patient pressed the button, starting the machine, the saline solution was switched a solution of thiopental that was set on a 60 second timer. Once the 60-second mark was reached, the machine then switched to a third solution, potassium chloride. Thiopental was given first to the patient in order to induce a coma minutes before death by heart failure due to potassium chloride (Frontline, 1994).

Figure 4: Dr. Kevorkian with his "Suicide Machine".

3 Advanced Directives

According to the U.S. Supreme Court, it is each individual's constitutional right to control his/her own medical treatment (Cruzan v. Director, Mo. Dep't of Health, 497 U.S. 261, 1990). An Advanced Directive is a legal document used to protect this constitutional right through allowing a competent adult to declare in advanced his/her wishes concerning his/her own medical care. This document helps to prevent confusion for health care professionals, family and friends regarding the patient's end-of-life care wishes in a situation where the patient may be unable to make or communicate his/her decisions (National Cancer Institute, 2000).

3.1 Living Will

A Living Will is a legal document detailing the desires of a patient in regard to life sustaining treatment. Living Wills remove the burden of decision making from the family, while also assuring the patient that if s/he becomes seriously ill or debilitated his/her requests will be met. Patients can rest a bit easier in knowing that if s/he are ever incapable of either making or communicating a health care decision, that his/her wishes will be recognized.

The National Cancer Institute (2000) recommends that the following health care decisions to be considered for a Living Will:

- The use of life-sustaining equipment such as dialysis machines, ventilators, respirators, artificial hydration and nutrition
- "Do Not Resuscitate" (DNR) Orders, also known as CPR Directives in some states, which are instructions to not use CPR if breathing or heartbeat stops
- Use of "aggressive medical treatment" / Palliative care choices
- Organ and tissue donation

Declaring not to receive "aggressive medical treatment" is not the same as declaring all medical treatment withheld. It does not exclude palliative treatment such as receiving antibiotics, nutrition, pain medication, or radiation therapy (National Cancer Institute, 2000).

It is assumed in an emergency situation that the patient consents to receiving medical treatment, including resuscitation. If a patient does not wish to receive such treatment it is their obligation to communicate their decision to others through an advanced directive. Without a DNR Order or a CPR Directive, health care professionals will initiate CPR; therefore it is important for the patient to communicate their desires and information concerning their advanced directive documents – such as location – with others. Some states, such as Ohio, go as far as selling CPR Directive bracelets and necklaces in order for health care workers to easily identify the patient wishes to decline resuscitation (The Memorial Hospital, 2004).

3.2 Durable Power of Attorney / Health Care Proxy

A Durable Power of Attorney and a Health Care Proxy, are a legal documents in which a 'Principal' declares a 'Health Care Agent', to be granted selective authority over health care decisions, should the Principal ever be incapable of making or communicating a decision for him/herself. Which document is used, and the details of that document differ from state to state, although a Durable Power of Attorney tends to focus on financial rather than medical representation. It is required by *The Massachusetts Health Care Proxy* that all parties involved be at least 18 years of age; and that unless related by blood, marriage or adoption, any employee of the health care facility at which the Principal is a patient cannot be declared as an Agent (*Health Care Proxy Law*: Massachusetts General Laws, Chapter 201D; *Massachusetts Health Care Proxy: Information, Instructions, and Form*). It is the responsibility of the Principal to

make a conscientious decision of who they trust with their life and to also communicate their requests with whomever they choose. The Agent receives authority only after a doctor has declared, in writing, that the Principal is incapable of making health care decisions. The Principal must either specify limits to the amount of authority, or grant full authority to their Agent. The Agent is allowed access to any information, including confidential medical files, in order to make a well-informed decision for the Principal. When an Agent is granted full authority, s/he decides whether to consent to or refuse medical treatment, even when that treatment could save the Principal's life. The object behind any Durable Power of Attorney, no matter the state, is for every patient to have a voice, even when they are unable to communicate. The Principal can override the Agent's decision, unless a court has ruled the Principal to lack the capacity to make his or her own health care decisions. An Alternate Agent can be declared by the Principal in the situation that the original Agent is unable or refuses to act (*Massachusetts Health Care Proxy: Information, Instructions, and Form,* 1999).

3.3 Terri Schiavo

It was a hard question to answer; whether Theresa Marie Schiavo (Figure 5) was really in a persistent vegetative state (PVS) as the courts had ruled, or if rather, if she was in a 'minimally conscious state' as her actions sometimes suggested. On February 25, 1990, due to a potassium deficiency resulting from a history of bulimia, 27-year-old Theresa suffered a heart attack. Her heartbeat was restored to normal after many failed defibrillating attempts, but only after her brain had received irreparable damage from having been depleted of oxygen for over 40 minutes. After three months in a coma, Terri Schiavo awoke into a PVS, clearly having suffered severe brain damage (Affidavit of William Cheshire, Jr., MD 03-23-05; Didion, 2005).

Figure 5: Theresa Marie Schiavo, as a young adult, prior to the heart attack which left her awake but unaware.

Patients diagnosed with PVS, although awake in the sense of normal sleep-wake cycles, are unaware and lack ability to think (Didion, 2005). A result of severe brain damage, PVS was the neurological diagnosis of Terri Schiavo, after her cardiac arrest. A PVS patient's body maintains most, if not all, autonomic functions – heart rate, digestion, circulation, etc. – as a result of involuntary brain stem reflexes. With no integrated function of the cerebral cortex, a patient is not capable of voluntary movement; therefore, any response is merely reflexive. Although it is possible for a patient to regain consciousness and function, it is also possible for a patient to remain in a PVS for over 15 years. The longer a patient is in a PVS, the less of a chance they have of recovery (Appendix IV). Fifteen years was how long Terri Schiavo remained in a PVS, until the day she died, March 31, 2005. After a highly publicized and disconcerting battle over guardianship – her parents, Robert and Mary Schindler in one corner versus her widower, Michael Schiavo in the other – her feeding tube was removed. Theresa Marie Schiavo lived only 13 days after the removal of the feeding tube that had kept her alive for the past 15 years (CBC News, 2005).

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Removing life support is not a novel proposal; nevertheless Schiavo's story received much attention from the media for a variety of reasons including the high-stakes and emotionally charged nature of the case. Neurologists were unsure whether Terri should be diagnosed as in a PVS or a "minimally conscious state" (MCS). Since 2002, MCS has been used as an alternative diagnosis to PVS, differentiating between patients who at times able to respond and those who are truly in a 'persistent vegetative state'. In a MCS, unlike a PVS, the patient is at times aware of her

surroundings and therefore aware of any pain, discomfort or abuse. The ability of an MCS patient to respond to the environment implies thought even if the patient is incommunicable. Simply put, PVS lacks any and all conscious thought, while MCS has random periods of awareness (Didion, 2005).

It was unclear how to diagnose Terri, and after the introduction of MCS as a possible diagnosis, the issue became all the more complicated. Doctors began to argue that Terri was not a PVS patient, but that she was aware from time to time. As Dr. Cheshire remembers, Terri looked up in response of his entering the room; something a PVS patient, by definition, would be incapable of (Affidavit of William Cheshire, Jr., MD 03-23-05; Didion, 2005). With a large sum of money ($750,000) that her husband, Michael, stood to inherit, his motives for wanting to withdraw feeding tubes and hydration from Terri were an issue. Her parents were sickened by what Michael had requested and fought to gain custody of their daughter (Didion, 2005).

Figure 6: Theresa Marie Schiavo, post-cardiac arrest; Argued to be in either a Persistent Vegetative State or a Minimally Conscious State.

Although a tragedy, Terri's death educated millions on the importance of advanced directives and preparing for such unfortunate circumstances. Had she completed a Durable Power of Attorney, it would have been clear who she trusted most to make such critical medical decisions. Legally speaking, the removal of Terri's food and water is classified as the withdrawal of treatment. There is a fine line between the difference of such acts, assisted suicide, and euthanasia; as a result the questions of who, if anyone has the right to die, and who has the right to decide for them are ever changing with today's society.

Final Notes

It is clearly understood by all, that this issue is far from settled. This is an area of science that is soaked in ethics, and ones own personal beliefs. Some question if there should even be a law at all, and to this I would have to say, of course. There is a never-ending supply of questions concerning assisted suicide, and some which were not directly addressed in this discussion, include the precautions that need to be taken when considering such an act. Without a law to protect a physician who fulfills a terminally ill patient's request for aid in dying, he could be liable for prosecution for manslaughter. There is also the concern over family members or doctors who are burdened by the expense or time required in caring for a terminal patient; that they might coerce the patient into considering death their only option. Patients need to be protected from ulterior motives of those they trust; such was part of the controversy over withdrawal of treatment from Terri Schiavo. The first step in doing this is preparing for the end, filing advanced directives and communicating end-of-life wishes with doctors, family, and friends.

There was once a time when an ill person simply died. There was not the option of life-sustaining treatment. With new technologies that can extend life when no recovery is possible, it is perhaps time to revisit the ethics of medicine. Is it right to keep a patient alive artificially?

Some might say this is playing God, because without artificial life-support, the patient would naturally die. So why then is it acceptable to prolong a suffering person's life, and not acceptable to let them go?

Appendix II presents a series of pieces all corresponding to a survey sent out to over 400 potential participants. Surveys were given to both students and parents of WPI students. Few students returned their surveys, while nearly half of the parents responded. This shows discretion between age and the significance of end-of-life matters to an individual; but as Terri Schiavo showed the world, a prolonged death, knows no age. A handful of parents not only returned surveys but also returned essays and letters, documenting personal accounts and beliefs on the subject. Due to unforeseen circumstances, the surveys were lost, although the response rate and enthusiasm shown by the respondents were most encouraging. This is an incredibly important and open ended issue that most of you will be unable to avoid. A documented statement of your philosophy will ease both your mind and those of your caregivers in your final days. The time to decide where you stand on end-of-life issues is not when your life is ending.

Appendix

Appendix I. 3rd Edition of the *Standards for the Provision of Palliative Care (PCA, 1999)*

Quality end of life care is provided by health care workers who:
*1. endeavor to maintain the **dignity** of the patient, their caregiver/s and family;*
*2. work with the strength and limitations of the and their caregiver/s and family to **empower** them in managing their own situation;*
*3. act with **compassion** towards the patient and their caregiver/s and family;*
*4. consider **equity** in the accessibility of services and the allocation of resources;*
*5.demonstrate **respect** for the patient, their caregiver/s and family;*
*6. **advocate** on behalf of the expressed wished of patients, caregiver/s, families, and communities;*
*7. are committed to the pursuit of **excellence** in the provision of care and support;*
*8. are **accountable** to patients, caregiver/s. families and the community.*

Appendix IIa. Cover letter attached to the survey sent out to WPI students.

Hello, February 1, 2005

My name is Jennifer Goscila and I am conducting the following survey on assisted suicide as part of my IQP. This survey should not take more than ten minutes and will be a vital part to this project. Once the survey is completed you can drop it into the box labeled "Assisted Suicide IQP Surveys" located on the bottom floor of the campus center by the mail boxes. To obtain a broader range of opinions the following survey has also been sent to your parents. Both surveys will remain completely confidential. There is a List of Terms on the back page for any clarification of ideas that are mentioned in this survey.

Thank you for your thoughts on this subject.

Jennifer Goscila
jennifer@wpi.edu
Advisor: Dr. Gibson

For any additional questions please feel free to contact my advisor

Dr. Gibson. Email: dgibson@wpi.edu
Phone: (508)831-5144.

Appendix IIb. Cover letter attached to the survey sent out to WPI parents.

Hello, February 1, 2005

My name is Jennifer Goscila and I am a classmate of your son/daughter at WPI. I have asked him/her to complete the following survey concerning assisted suicide for my Interactive Qualifying Project (IQP). The IQP is a graduation requirement that your son/daughter will be required to complete to receive their degree. Along with your son/daughter's opinion on this topic, I would like to know what you think by filling out the enclosed survey. Both surveys will remain completely confidential. There is a List of Terms on the back page for any clarification of ideas that are mentioned in this survey. Once completed, please return the survey in the enclosed envelope (no stamp needed).

Thank you for your thoughts on this subject. This survey should not take more than ten minutes, and the information collected in this survey will be a vital part to this project.

Jennifer Goscila
jennifer@wpi.edu
Advisor: Dr. Gibson

For any additional questions please feel free to contact my advisor

Dr. Gibson. Email: dgibson@wpi.edu
Phone: (508)831-5144

Appendix IIc. Survey given to both students and also sent out to parents of WPI students.

ASSISTED SUICIDE

IQP SURVEY

GENDER: M ___ F ___ AGE: _____

WOULD YOU DESCRIBE YOURSELF AS…

___ Very Liberal ___Liberal

___ Very Conservative ___Conservative

EACH OF THE FOLLOWING IS MORALLY JUSTIFIABLE BEHAVIOR:

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Voluntary Euthanasia	O	O	O	O	O
Assisted Suicide	O	O	O	O	O
Withdrawal of Treatment	O	O	O	O	O
Abortion	O	O	O	O	O
In Vitro Fertilization	O	O	O	O	O

DO YOU BELIEVE THAT THE LEGALITY OF FOLLOWING SHOULD BE DECIDED BY:

	State Law	National Law	Individual Conscience
Voluntary Euthanasia	O	O	O
Assisted Suicide	O	O	O
Withdrawal of Treatment	O	O	O
Abortion	O	O	O
In Vitro Fertilization	O	O	O

DO YOU BELIVE THAT THE FOLLOWING SHOULD BE:

	Legal	Illegal
Voluntary Euthanasia	O	O
Assisted Suicide	O	O
Withdrawal of Treatment	O	O
Abortion	O	O
In Vitro Fertilization	O	O

WHICH OF THE FOLLOWING WORRY YOU MOST ABOUT THE LEGALIZATION OF ASSISTED SUICIDE:

___Coercion

___Assisted suicide due to mental conditions such as depression

___Incorrect diagnoses and prognoses leading to assisted suicide

___Loss of professional integrity

___Other: _____

HAVE YOU EVER KNOWN SOMEONE WHO HAS: (check all that apply)

___ Requested assisted suicide

___Actually committed assisted suicide

If so, was the family informed of the decision before the act? ___Yes ___ No

___Would have benefited from assisted suicide

___Was taken off life support

If so, was this a family decision? ___Yes ___No

___Had an abortion

___Tried in vitro fertilization

WHAT IS YOUR OPINION ON THE FOLLOWING STATEMENT:

"A PERSON HAS THE RIGHT TO DECIDE WHEN HIS/HER LIFE WILL END"*

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
O	O	O	O	O

WHAT IS YOUR OPINION OF THE FOLLOWING STATEMENT:

THE PATIENT'S FAMILY HAS A RIGHT TO VETO A REQUEST FOR ASSISTED SUICIDE.

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
O	O	O	O	O

HOW LIKELY IS IT THAT YOU WOULD EVER CONSIDER ASSISTED SUICIDE FOR YOURSELF OR A LOVED ONE?

Very Likely	Likely	Not Likely	Not at all Likely
O	O	O	O

IF ASSISTED SUICIDE WAS LEGAL HOW LIKELY IS IT THAT YOU WOULD EVER CONSIDER IT AS AN OPTION FOR YOURSELF OR A LOVED ONE?

Very Likely	Likely	Not Likely	Not at all Likely
O	O	O	O

HAVE YOU EVER COMPLETED A: (check all that apply)

___Durable Power of Attorney for Healthcare

___Living Will for your state

___Healthcare Proxy for your state

AFFILIATED RELIGION:

___Eastern Orthodox

___Catholic

___Protestant

___Jewish

___Jewish- Orthodox

___Hindu

___Buddhist

___Muslim

___Other: _____

DO YOU CONSIDER YOURSELF A PRACTICING MEMBER OF YOUR FAITH?

___Very Much

___Moderate

___Not at all

DO YOU PRAY/MEDITATE FOR YOUR FAITH?

___At least once a day

___At least once a week

___At least once a month

___Less than once a month

___Never

ADDITIONAL COMMENTS PERTAINING TO ASSISTED SUICIDE: _____

_____

_____

_____

_____

_____

*http://www.endoflifeissues.org.uk/survey.asp

Appendix IId. The 'List of Terms' that accompanied each survey.

LIST OF TERMS

ABORTION: The medically induced termination of pregnancy resulting in the death of the embryo.

ASSISTED SUICIDE: A procedure currently illegal in the United States, excluding Oregon where it is legal under specific conditions, where a physician supplies the means for a terminally ill patient to commit suicide. An example of assisted suicide would be a doctor prescribing an overdose to the patient. The main difference between assisted suicide and voluntary euthanasia is in assisted suicide the patient is the one to "pull the trigger".

DURABLE POWER OF ATTORNEY FOR HEALTHCARE: A legal document in which you appoint a trusted person as your attorney-in-fact to speak for you if ever become incapacitated. The attorney-in-fact may be responsible for a multitude of things from making basic medical decisions on your behalf to paying your bills.

HEALTHCARE PROXY: A legal document, specific to each state, which allows you to give specific healthcare instructions and guidelines. It also allows you to appoint a trusted person to make healthcare decisions for you concerning any healthcare decisions you did not anticipate and are incapable of making. This is different from the Durable Power of Attorney for Healthcare because the former deals primarily with meeting financial obligations and not so much with making serious healthcare decisions.

IN VITRO FERTILIZATION: A process used typically by couples suffering from infertility, by which an unfertilized egg is removed from a woman to be fertilized with sperm in a dish, the term *in* vitro being Latin for "in glass." After the egg is fertilized it is placed back into the woman's uterus with the hope that it will implant and the woman will be pregnant.

LIVING WILL: A legal document, specific to each state, allowing you to specify what life sustaining treatment you want if you are terminally ill and unable to make the decision for yourself.

VOLUNTARY EUTHANASIA: When a physician, upon request, actively participates in the termination of a terminally ill patient's life. The main difference between voluntary euthanasia and assisted suicide is that with voluntary euthanasia the doctor is the one to "pull the trigger".

WITHDRAWAL OF TREATMENT: The withdrawal of life support that will result in the termination of the patient's life.

Appendix III. The following list of 93 patients who Kevorkian aided in suicide (ERGO.com, 1998).

Name	Year	Sex	Age	Diagnosis
Adkins, Janet	1990	F	54	Alzheimer's Disease
Miller, Sherry	1991	F	43	Multiple Sclerosis
Wantz, Marjorie	1991	F	58	Abdominal & Pelvic Pain
William, Susan	1992	F	52	Multiple Sclerosis
Hawes, Lois F.	1992	F	52	Lung Cancer
Andreye, Catherine	1992	F	46	Breast Cancer
Tate, Marguerite	1992	F	70	ALS
Lawrence, Marcella	1992	F	67	Heart Disease, Emphysema, Failing Liver & Arthritis
Williams, Sue Weaver	1992	F	52	Multiple Sclerosis
Miller, Jack. E.	1993	M	53	Bone Cancer
Ball, Stanley	1993	M	82	Pancreatic Cancer & Blind
Biernat, Mary	1993	F	73	Breast Cancer
Goldbaum, Elaine	1993	F	47	Multiple Sclerosis
Gale Sr., Hugh E.	1993	M	70	Emphysema & Congestive Heart Disease
Ruwart, Martha	1993	F	41	Duodenal & Ovarian Cancer
Grenz, Jonathon	1993	M	44	Mouth & Throat Cancer
Mansur, Ronald	1993	M	54	Bone & Lung Cancer
Hyde Jr., Thomas	1993	M	30	ALS
O'Keefe, Donald	1993	M	73	Bone Cancer
Frederick, Merian	1993	F	72	ALS
Khalili, Ali	1993	M	61	Bone Cancer
Garrish, Margaret	1994	F	72	Osteoporosis, Rheumatoid Arthritis, Colonic Diverticulitis, Loss of Eye & Amputated Legs
Evans, John	1995	M	78	Pulmonary Fibrosis
Loving, Nicholas	1995	M	27	ALS
Garcellan, Erika	1995	F	60	ALS
Cohan, Esther	1995	F	45	Painful Ulcers & Multiple Sclerosis
Cashman, Patricia	1995	F	58	Breast Cancer & Bone Cancer‡
Henslee, Linda	1996	F	48	Multiple Sclerosis
Bastable, Austin	1996	M	53	Multiple Sclerosis
Neuman, Ruth	1996	F	69	Uterine Cancer, Diabetes, Stroke & Paralysis
Jones, Lona	1996	F	58	Brain Cancer
Hamilton, Bette Lou	l996	F	67	Syringemyelia
Kline, Shirley	1996	F	63	Bowel Cancer
Badger, Rebecca	1996	F	39	Multiple Sclerosis†
Mertz, Elizabeth	1996	F	59	ALS
Curren, Judith A.	1996	F	42	Chronic Fatigue & Immune Dysfunction Syndrome
Siebens, Louise	1996	F	76	ALS
Smith, Patricia	1996	F	40	Multiple Sclerosis

Name	Year	Sex	Age	Diagnosis
DiGangi, Pat	1996	M	66	Cancer & Stroke
Leatherman, Jack	1996	M	73	Pancreatic Cancer
Correa, Isabel	1996	F	60	Spinal Diseases & Pain
Faw, Richard	1996	M	71	Colon Cancer
Spolar, Wallace J.	1996	M	70	Multiple Sclerosis
de Soto, Nancy	1996	F	55	ALS
Collins, Barbara A.	1996	F	65	Ovarian Cancer
Peabody, Loretta	1996	F	54	Multiple Sclerosis
Day, Elaine Lousie	1997	F	79	ALS
Lansing, Lisa	1997	F	42	Crohn's Disease
Livengood, Helen P.	1997	F	59	Severe Arthritis Pain & Crippling Esophagus Problems
Miley, Albert	1997	M	41	Quadriplegia
Knowles, Janette	1997	F	75	ALS
Aseltine, Heidi	1997	F	27	AIDS
Bacher, Delouise	1997	F	63	Multiple Sclerosis
Murphy, Janis	1997	F	40	Fibromyalgia & Chronic Fatigue Syndrome
Lennox, Lynne	1997	F	54	Multiple Sclerosis
Scheipsmeier, Dorinda	1997	F	51	Multiple Sclerosis
Shoffstal, Karen	1997	F	34	Multiple Sclerosis
Good, Janet	1997	F	73	Pancreatic Cancer
Summerlee, Thomas	1997	M	55	Multiple Sclerosis
Fox, Carol	1997	F	50's	Ovarian Cancer
Sickels, Deborah	1997	F	43	Multiple Sclerosis
Thakore, Natverlal	1997	M	78	Parkinson's Disease
Miller, Kari	1997	F	54	Multiple Sclerosis
Zdnaowicz, John	1997	M	50	ALS
Caswell, Lois Carol Hawkins	1997	F	65	Chronic Pain Syndrome
Blackman, Annette	1997	F	34	Multiple Sclerosis
O'Haria, John	1997	M	54	Stroke, Gout & Kidney Problems
Foldes, Naida	1997	F	72	Cancer
Sachs, Naomi	1997	F	84	Osteoporosis
Gross, Bernice	1997	F	78	Multiple Sclerosis
Wichorek, Martha	1997	F	82	Various Ailments
Hass, Rosalind	1997	F	59	Breast Cancer
Tremble, Cheri	1997	F	46	Breast Cancer
Weilhard, Margaret	1997	F	89	Stroke, Paralysis & Blindness
Langford, Mary	1997	F	73	Breast & Lung Cancer
Long, Franz-Johann	1998	M	53	Bladder Cancer ‡
Rush, Nancy Ruth	1998	F	81	Lung Cancer, Emphysema & Ulcers
Hunter, Carrie	1998	F	35	AIDS
Allen, Jeremy	1998	M	52	Kidney Cancer

Name	Year	Sex	Age	Diagnosis
Clement, Muriel	1998	F	76	Advanced Parkinson's Disease
Dawson, Roosevelt	1998	M	21	Quadriplegia
Greyham, Patricia	1998	F	61	Rheumatoid Arthritis
Connaughton, William	1998	M	42	Fibromyalgia
Herman, Waldo	1998	M	66	Lung Cancer
Judith Kanner, Mary	1998	F	67	Huntington's Disease
Semonic, Shala	1998	F	47	ALS
Wilson, Colleen	1998	F	74	ALS
Schenbern, Jack	1998	M	89	Prostate Cancer
Hiles, Priscilla	1998	F	73	Chronic Arthritis, Sciatica, Asthma & Degenerative Disk Disease
Alderman, Lucille	1998	F	86	Osteoarthritis & Heart Disease
Johnson, Mathew	1998	M	26	Quadriplegia
Kass, Emma	1998	F	68	Lung Cancer
Tushkowski, Joseph	1998	M	45	Quadriplegia
† Disputed by Medical Examiner, ‡ Uncertain				

Appendix IV. From the Multi-Society Task Force on PVS (1994); "**Table 4.** Probability of Recovery of Consciousness and Function at 12 Months in Adults and Children in a Persistent Vegetative State (PVS) Three or Six Months after Traumatic or Nontraumatic Injury."

OUTCOME	ADULTS		CHILDREN	
	TRAUMATIC INJURY (N = 434)	NONTRAUMATIC INJURY (N = 169)	TRAUMATIC INJURY (N = 106)	NONTRAUMATIC INJURY (N = 45)
	% of patients (99% confidence interval)			
Patients in PVS for 3 months†				
Death	35 (27–43)	46 (31–61)	14 (1–27)	3 (0–11)
PVS	30 (22–38)	47 (32–62)	30 (13–47)	94 (83–100)
Severe disability	19 (12–26)	6 (0–13)	24 (8–40)	3 (0–11)
Moderate disability or good recovery	16 (10–22)	1 (0–4)	32 (15–49)	0
Patients in PVS for 6 months‡				
Death	32 (21–43)	28 (12–44)	14 (0–31)	0
PVS	52 (40–64)	72 (56–88)	54 (30–78)	97 (89–100)
Severe disability	12 (4–20)	0	21 (1–41)	3 (0–11)
Moderate disability or good recovery	4 (0–9)	0	11 (0–26)	0

*Conditional probabilities were determined from data in Table 3. The numbers of patients given in parentheses refer to the numbers of patients who were in a vegetative state one month after injury.

†A total of 218 adults with traumatic injuries, 77 adults with nontraumatic injuries, 50 children with traumatic injuries, and 31 children with nontraumatic injuries.

‡A total of 123 adults with traumatic injuries, 50 adults with nontraumatic injuries, 28 children with traumatic injuries, and 30 children with nontraumatic injuries.

Appendix V. Regulations regarding Advanced Directives by state (The Wall Street Journal, 2005; the Nightingale Alliance, 1999).

State	Regulation of Advanced Directives	Legislation on Assisted Suicide
Alabama	*Advance Directive:* 2 witnesses; not valid if pregnant	No law; may be prosecuted as manslaughter
Alaska	*Living Will* *Health Care Proxy:* 2 witnesses; allows only general medical decision making	Prohibited by law
Arizona	*Living Will*: witness & a notary *Health Care Proxy*: witness & a notary	Prohibited by law
Arkansas	*Advance Directive*: 2 witnesses; not valid if pregnant	Prohibited by law
California	*Living Will*: 2 witnesses; not valid if pregnant *Health Care Proxy:* 2 witnesses or a notary	Prohibited by law
Colorado	*Living Will:* 2 witnesses; not valid if pregnant *Health Care Proxy*	Prohibited by law
Connecticut	*Advance Directive:* 2 witnesses/notaries	Prohibited by law
Delaware	*Advance Directive:* 2 witnesses	Prohibited by law
District of Columbia	*Living Will:* 2 witnesses *Health Care Proxy:* 2 witnesses	No law; may be prosecuted as manslaughter
Florida	*Living Will:* 2 witnesses *Health Care Proxy:* 2 witnesses	Prohibited by law
Georgia	*Living Will:* 2 witnesses; not valid if pregnant *Health Care Proxy:* 2 witnesses	Prohibited by law
Hawaii	*Living Will*: 2 witnesses & a notary; not valid if pregnant *Health Care Proxy:* 2 witnesses & a notary	No law; may be prosecuted as manslaughter
Idaho	*Living Will*: 2 witnesses; not valid if pregnant *Health Care Proxy:* 2 witnesses & a notary	No law; may be prosecuted as manslaughter
Illinois	*Living Will*: 2 witnesses; not valid if pregnant *Health Care Proxy:* 1 witness	Prohibited by law
Indiana	*Living Will:* Specifies A or B where 'Declaration B' says patient wants all life-prolonging procedures taken; 2 witnesses; not valid if pregnant *Health Care Proxy:* a notary	Prohibited by law
Iowa	*Living Will*: 2 witnesses; not valid if pregnant *Health Care Proxy:* 2 witnesses or a notary	Prohibited by law
Kansas	*Living Will:* 2 witnesses or notary	Prohibited by law

State	Regulation of Advanced Directives	Legislation on Assisted Suicide
Kentucky	*Advance Directive:* *Living Will (Section 2):* 2 witnesses or a notary; not valid if pregnant *Health Care Proxy (Section 1)*: 2 witnesses	Prohibited by law
Louisiana	*Advanced Directive*: 2 witnesses	Prohibited by law
Maine	*Advance Directive*: Section I & Section 2; 2 witnesses	Prohibited by law
Maryland	*Living Will:* 2 witnesses *Health Care Proxy*: 2 witnesses	Prohibited by law
Massachusetts	*Living Will* *Health Care Proxy:* 2 witnesses	No law; may be prosecuted as manslaughter
Michigan	*Living Will* *Health Care Proxy:* 2 witnesses	Prohibited by law
Minnesota	*Living Will*: 2 witnesses or a notary; not valid if pregnant *Health Care Proxy*: 2 witnesses or a notary	Prohibited by law
Mississippi	*Advance Directive*: 2 witnesses or a notary	Prohibited by law
Missouri	*Living Will*: 2 witnesses, not valid if pregnant *Health Care Proxy:* 2 witnesses or a notary	Prohibited by law
Montana	*Living Will:* 2 witnesses	Prohibited by law
Nebraska	*Living Will:* 2 witnesses or a notary	Prohibited by law
Nevada	*Living Will:* 2 witnesses *Health Care Proxy:* 2 witnesses or a notary	No law; may be prosecuted as manslaughter
New Hampshire	*Living Will:* 2 witnesses & a notary or justice of the peace *Health Care Proxy:* 2 witnesses or a notary or a justice of the peace	Prohibited by law
New Jersey	*Living Will:* 2 witnesses or a notary *Health Care Proxy:* 2 witnesses or a notary	Prohibited by law
New Mexico	*Living Will* *Health Care Proxy*	Prohibited by law
New York	*Living Will:* 2 witnesses *Health Care Proxy*: 2 witnesses	Prohibited by law
North Carolina	*Declaration of desire for a natural death:* 2 witnesses & a notary *Health Care Proxy:* 2 witnesses & a notary	No law; may be prosecuted as manslaughter
North Dakota	*Living Will:* 2 witnesses, not valid if pregnant *Health Care Proxy*: 2 witnesses	Prohibited by law
Ohio	*Living Will:* 2 witnesses or a notary, not valid if pregnant unless doctors anticipate a still birth *Health Care Proxy:* 2 witnesses or a notary	Prohibited by law
Oklahoma	*Living Will:* 2 witnesses, not valid if pregnant *Health Care Proxy*: 2 witnesses	Prohibited by law

State	Regulation of Advanced Directives	Legislation on Assisted Suicide
Oregon	*Living Will*: 2 witnesses *Health Care Proxy:* 2 witnesses.	Legal for terminally ill patients under The Oregon Death with Dignity Act, 1994.
Pennsylvania	*Living Will:* 2 witnesses, not valid if pregnant *Health Care Proxy* is part of the declaration.	Prohibited by law
Rhode Island	*Living Will* requires two witnesses, not valid if pregnant unless doctors anticipate a still birth *Health Care Proxy:* 2 witnesses	Prohibited by law
South Carolina	*Declaration of desire for a natural death*: 2 witnesses & a notary *Health Care Proxy:* 2 witnesses	Prohibited by law
South Dakota	*Living Will:* 2 witnesses, not valid if pregnant *Health Care Proxy:* 2 witnesses or a notary.	Prohibited by law
Tennessee	*Living Will:* 2 witnesses *Health Care Proxy:* 2 witnesses, a notary is optional	Prohibited by law
Texas	*Living Will:* 2 witnesses, not valid if pregnant *Health Care Proxy:* 2 witnesses	Prohibited by law
Utah	*Living Will*: 2 witnesses, not valid if pregnant *Health Care Proxy:* a notary	No law; may be prosecuted as manslaughter
Vermont	*Living Will*: 2 witnesses, not valid if pregnant *Health Care Proxy*: 2 witnesses or a notary.	No law; may be prosecuted as manslaughter
Virginia	*Advance Directive:* 2 witnesses	Prohibited by law
Washington	*Living Will:* 2 witnesses, not valid if pregnant *Health Care Proxy:* witness recommended	Prohibited by law
West Virginia	*Living Will*: 2 witnesses & a notary *Health Care Proxy:* 2 witnesses & a notary.	No law; may be prosecuted as manslaughter
Wisconsin	*Living Will:* 2 witnesses, not valid if pregnant *Health Care Proxy:* 2 witnesses	Prohibited by law
Wyoming	*Living Will*: 2 witnesses; not valid if pregnant *Health Care Proxy:* 2 witnesses & a notary	No law; may be prosecuted as manslaughter
Advanced Directive implies both a *Living Will* and a *Health Care Proxy* on a single document. *Euthanasia* is prohibited under general homicide laws in all states.		

Appendix VI. The Hippocratic Oath; original version written by Hippocrates in 400 B.C.. Translated by Francis Adams in 1886. (The Genuine Works of Hippocrates, vol.1: 105-106.)

I SWEAR by Apollo the physician, and Aesculapius, and Health, and All-heal, and all the gods and goddesses, that, according to my ability and judgment, I will keep this Oath and this stipulation- to reckon him who taught me this Art equally dear to me as my parents, to share my substance with him, and relieve his necessities if required; to look upon his offspring in the same footing as my own brothers, and to teach them this art, if they shall wish to learn it, without fee or stipulation; and that by precept, lecture, and every other mode of instruction, I will impart a knowledge of the Art to my own sons, and those of my teachers, and to disciples bound by a stipulation and oath according to the law of medicine, but to none others.

I will follow that system of regimen which, according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous. I will give no deadly medicine to any one if asked, nor suggest any such counsel; and in like manner I will not give to a woman a pessary to produce abortion. *With purity and with holiness I will pass my life and practice my Art. I will not cut persons laboring under the stone, but will leave this to be done by men who are practitioners of this work.*

Into whatever houses I enter, I will go into them for the benefit of the sick, and will abstain from every voluntary act of mischief and corruption; and, further from the seduction of females or males, of freemen and slaves. Whatever, in connection with my professional practice or not, in connection with it, I see or hear, in the life of men, which ought not to be spoken of abroad, I will not divulge, as reckoning that all such should be kept secret. While I continue to keep this Oath unviolated, may it be granted to me to enjoy life and the practice of the art, respected by all men, in all times! But should I trespass and violate this Oath, may the reverse be my lot!

Literature Cited

1. Adams, F., LL.D. (1886). The Oath of Hippocrates (translated from Greek), *The Genuine Works of Hippocrates* (pp.105-106). Huntington, N.Y.: Robert E. Krieger Publishing Company.

2. Anderson, M.A. (2007) *Caring for Older Adults Holistically 4th Ed.* Philadelphia, PA : F. A. Davis Company.

3. Bachman, J.G., Ph.D., Alcser, K.H., Ph.D., Doukas, D.J., M.D., Lichtenstein, R.L., Ph.D., Corning, A.D., M.A., & Brody, H., M.D., Ph.D. (1996). Attitudes of Michigan Physicians and the Public Toward Legalizing Physician-Assisted Suicide and Voluntary Euthanasia. *New England Journal of Medicine*, 334(5), 303-309.

4. Basson, M.D. (1981). Introduction: Rational Suicide. In *Progress in Clinical and Biological Research Volume 50* (pp. 179-181). New York: Alan R. Liss, INC.

5. Betzold, M. (1993). *Appointment with Doctor Death*. Troy, MI: Momentum Books Ltd

6. CBC News Online (2005). *In Depth: Terri Schiavo*. Retrieved from the CBC News website: http://www.cbc.ca/news/background/schiavo/

7. Cheshire, W., Jr., M.D. (2005). *Affidavit of William Cheshire, Jr., MD 03-23-05*. Duval Country, FL.

8. CNN. (1999). *Youk's wife upset as jury weighs Kevorkian's fate.* Retrieved from the CNN website: http://www.cnn.com/US/9903/25/kevorkian.04/

9. Cohen-Almagor, R. (2003). Non-Voluntary and Involuntary Euthanasia in the Netherlands: Dutch Perspectives. *Issues in Law and Medicine*, 18(3).

10. Compassion and Choices (2005). *Glossary*. Retrieved from the Compassion and Choices website: http://www.compassionandchoices.org/aboutus/glossary.php

11. Didion, J. (2005). The Case of Theresa Schiavo. *The New York Review of Books*, 52 (10).

12. Durkheim, E. (1951). *Suicide*. Glencoe: Free Press.

13. *Frontline: The Kevorkian File*. (1994). Boston, MA.: WGBH Educational Foundation.

14. Groenewoud, J.H., M.D., van der Heide, A., M.D., Onwuteaka-Philipsen, B.D., Ph.D., Willems, D.L., M.D., Ph. D., van der Maas, P.J., M.D., Ph.D., & van der Wal, G., M.D., Ph.D. (2000). Clinical Problems with the Performance of Euthanasia and Physician-Assisted Suicide in the Netherlands. *New England Journal of Medicine*, 342(8), 551-556.

15. Hauerwas, S. (1981). Rational Suicide and Reasons for Living. In *Progress in Clinical and Biological Research Volume 50* (pp. 185-199). New York: Alan R. Liss, INC.

16. Hedberg, K., M.D., M.P.H. & Tolle, S.W., M.D. (2002). Physician-Assisted Suicide and Changes in Care of the Dying: The Oregon Perspective. In L. Snyder & A.L. Caplan

(Ed.), *Assisted Sucide: Finding Common Ground* (pp. 6-17). Bloomington: Indiana University Press.

17. Humphry, D. (2002). *Final Exit (3rd Ed.): The Practicalities of Self-Deliverance and Assisted Suicide for the Dying*. New York: Random House, Inc.

18. Hutchins, R.M. (1952). Hippocratic Writings: Biographical Note. In *Great Books of the Western World*.(Vol. 10, pp. ix). Chicago, IL.: William Benton.

19. Keränen, L. (2001). The Hippocratic Oath as Epideictic Rhetoric: Reanimating Medicine's Past for Its Future. *Journal of Medical Humanities*, 22(1), 55-68.

20. Kevorkian, J. (1991). *Prescription: Medicine*. New York: Prometheus Books.

21. King, N.M.P., J.D. (1996). *Making Sense of Advanced Directives*. Washington, D.C.: Georgetown University Press.

22. Kübler-Ross, E., M.D. (1969). *On Death and Dying*. New York: Scribner Classics.

23. Massachusetts Health Decisions (1999). *Massachusetts Health Care Proxy: Information, Instructions and Form.* Retrieved from the Massachusetts Medical Society website: http://www.massmed.org/AM/Template.cfm?Section=Search&TEMPLATE=/CM/ContentDisplay.cfm&CONTENTID=2570

24. Meier, D.E., M.D., Emmons, C.A., Ph.D., Wallenstein, S., Ph. D., Quill, T., M.D., Morrison, R.S., M.D., & Cassel, C.K., M.D. (1998). A National Survey of Physician-Assisted Suicide and Euthanasia in the United States. *New England Journal of Medicine*, 338(17), 1193- 1201.

25. Miller, F.G., Ph.D., Fins, J.J., M.D., & Snyder, L., J.D. (2002). Assisted Suicide and Refusal of Treatment: Valid Distinction or Distinction without a Difference? In L. Snyder & A.L. Caplan (Ed.), *Assisted Sucide: Finding Common Ground* (pp. 6-17). Bloomington: Indiana University Press.

26. Motto, J.A., M.D. (1981). Rational Suicide and Medical Ethics. In *Progress in Clinical and Biological Research Volume 50* (pp. 201-209). New York: Alan R. Liss, INC.

27. National Cancer Institute (2000). *Advanced Directives Fact Sheet*. Retrieved from the National Cancer Institute website: http://www.cancer.gov/cancertopics/factsheet/support/advance-directives

28. Nightingale Alliance (2003-2006). *Legal Status of Assisted Suicide/Euthanasia in the United States*. Retrieved from the Nightingale Alliance website: http://www.nightingalealliance.org/pdf/state_grid.pdf

29. Palliative Care Victoria. (2002). *Confusion and Terminal Restlessness*. East Melbourne, Vic. Retrieved from: http://www.pallcarevic.as.au.

30. Richards, D.W. (1987). Hippocrates and History: The Arrogance of Humanism. In R.J. Bulger (Ed.), *In Search of the Modern Hippocrates* (pp) Iowa City: University of Iowa Press.

31. Snyder, L. & Caplan, A.L. (2002). *Assisted Sucide: Finding Common Ground* (pp. 1-6). Bloomington: Indiana University Press.

32. The Council of Palliative Care Australia. (2006). *Standards for Providing Quality Palliative Care for all Australians*. Retrieved from the Council of Palliative Care Australia website: http://www.pallcare.org.au/Portals/9/docs/publications/Standards.pdf

33. The Memorial Hospital (2001-2006). *Advanced Directives.* Retrieved from The Memorial Hospital website: http://www.thememorialhospital.com/tmhc.nsf/HomePage/Home

34. The Multi-Society Task Force on PVS. (1994). Medical Aspects of the Persistent Vegetative State – Second of Two Parts. *New England Journal of Medicine* 330, 1572-1579.

Figure Citations:

Figure 1: http://wwwihm.nlm.nih.gov/ihm/images/B/14/555.jpg
Figure 2: http://www.empiriamagazin.com/Miszcellanea/Doktor%20Halal.htm
Figure 3: http://www.pbs.org/wgbh/pages/frontline/kevorkian/aboutk/art/god.html
Figure 4: http://www.deathreference.com/Ke-Ma/Kevorkian-Jack.html
Figure 5: http://www.folsomvillage.com/WorldArchives/PicturesOfTerrySchiavo.shtm
Figure 6: http://www.folsomvillage.com/WorldArchives/PicturesOfTerrySchiavo.shtm